

RETURN TO WORK EVALUATION FORM

**City of Scottsdale
Human Resources**

The City of Scottsdale will use the information provided by the employee's physician to help in determining the patient's work status. Thoughtful consideration in completing this form will, therefore, be greatly appreciated.

Today's Date:	
Employee Name:	
Employee Number:	
Date of Injury/Illness or Condition:	
Diagnosis	
Nature and Extent of Illness/Condition or Injury: (Please attach any continuation page(s) necessary to provide narrative of past medical history and current medical condition.)	
Current Medical Status of the above referenced Illness/Condition, or Injury. (Please include diagnosis and prognosis here.)	

CARE PROVIDED:

- ☐ **Physical Exam**
☐ **X-Ray**
☐ **Physical Therapy – Frequency/Duration**

- ☐ **Other**

- ☐ **Medication:**

Please list medications currently prescribed for the patient, their purpose, the how long (time period) the patient will need to take the medication, and the effect the medication could have on their physical or mental abilities to perform the duties of the attached job description.

- ☐ **Avoid Driving or Operating Machinery While Using This Medication**

ASSESSMENT OF PATIENT ABILITY TO PERFORM CURRENT JOB:

Attached is a copy of the Job Description for this position.

Can the patient currently be reasonably expected to perform the listed activities without being placed at some risk due to their medical or physical condition?

Please initial applicable response(s) and provide appropriate comments.

_____ **YES, the employee can perform the current job duties without any restrictions.**

_____ **YES, if the following conditions listed below can be met:**

Please list the conditions:

_____ **NO, the employee cannot currently be reasonably expected to perform the listed activities without being placed at risk.**

Please indicate reason(s) and explain:

If you answered "No" to the previous question, do you expect a fundamental or marked change in the future?

Please initial appropriate response(s) and provide appropriate comments.

_____ **NO.** If "no" please explain

_____ **YES.**

If "yes" please indicate when you feel the patient will recover sufficiently to perform duties

WORK STATUS:

☐ **Return to regular work on:**

☐ **Unable to work until:**

☐ **Return to transitional duty on: _____ for _____ days with the restrictions noted above.**

FOLLOW-UP CARE:

☐ **Estimated length of treatment:**

☐ Days ☐ Weeks ☐ Months

☐ **Scheduled for physician appointment on date:**

☐ **Scheduled for physical therapy on date:**

☐ **Referral:**

☐ **Discharged from care, stationary, with _____% impairment of**

SIGNATURE

Thank you for your assistance. If you have any questions, please contact _____, City of Scottsdale Human Resources at _____, FAX (480) 312-7960.

Physician Name:

(Please Print or Type)

Date:

Physician Signature:

Address:

Phone number:

Facsimile number: